**Add On Codes**

**Issue**

What methodology should CMS use to pay for "add-on" codes in the hospital OPPS?

**Background**

Currently "add-on" codes are paid through APCs like other services. However because CMS uses only single procedure claims to determine APC payments, and "add-on" codes cannot, by definition, ever appear on a single procedure claim, CMS is concerned that it will be difficult to pay accurately for "add-on" procedures"

The attached table contains the codes with which each 'add-on" procedure was billed most frequently.

We are concerned that the costs associated with "add-on" procedures may vary because (1) frequently "add-on" procedures may be billed with more than one base procedure, and (2) because "add-on" procedures themselves may be billed multiple times (e. g. "removal of each additional lesion" or "angioplasty of each additional vessel).

Moreover, some "add-on" procedures have a "T"status indicator (i. e. they are subject to the multiple procedure reduction rules) and other "add-on" procedures have an "S" status indicator (i. e. they are not subject to the multiple procedure reduction rules).

**Discussion**

CMS wants the panel to make recommendations concerning payment methodologies for "add-on" procedures

We would specifically like the panel to comment on the following options:

1. **Packaging the costs of "add-on" procedures with the "base" procedure.** This would mean that payment for the "base" procedure would reflect the frequency with which it was billed with the "add-on" procedure. No separate payment for the "add-on" procedure would be made; rather a portion of the payment for the "base" procedure would be for the "add-on" procedure. Under this proposal, as long as a hospital performed a mix of procedures reflecting the average use of the "add-on", payments, on average, would be appropriate. Hospitals that utilized the "add-on" procedure significantly less frequently than the average could receive overpayments for each procedure, while hospitals that utilized the "add-on" procedure significantly more frequently than average could receive underpayments.
2. **Continue to pay "add-on" procedures through APCs. If necessary place "add-on" procedures in their own APCs with appropriate status indicators.** This would require CMS utilize multiple procedure claims data to determine payment rates (for both the base procedure and the "add-on" procedure). It would also require

hospitals to accurately assign the costs attributable to the "add-on" procedure to the line item containing the "add-on" procedure. This option would require CMS to ensure accurate payment be made when a single "add-on" procedure is billed multiple times. Furthermore, if "add-on" procedures were performed infrequently or by very few hospitals, the cost data could be less reliable and payments might be inappropriate.

3. **Pay "add-on" procedures a percentage of the payment for the base procedure.** This option would require a change in our payment systems. It would be an acknowledgement that CMS is unable to obtain accurate cost or resource utilization data for these procedures and therefore can not determine payment for these procedures with our current methodology. CMS would need to develop a methodology (utilizing appropriate information) to determine what percentage of the base procedure to pay each "add-on".